CORNERSTONE ADMINISTRATIVE SERVICES, LLC

flexplan℠ for your benefit

MEDICAL REIMBURSEMENT CLAIM FORM

EMPLOYER NAME

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	WORK PHONE	HOME PHONE	EMAIL ADDRESS

UN-REIMBURSED MEDICAL EXPENSE CLAIMS

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
➢ Attach appropriate receipt(s) and submit with this claim form.		**TOTAL MEDICAL CARE EXPENSE CLAIM**		$

*****PLEASE DO NOT SEND ORIGINAL RECEIPTS/STATEMENTS**

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Flexible Spending Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

EMPLOYEE SIGNATURE

SIGNATURE	DATE

Mail or Fax claims to:

Cornerstone Administrative Services, LLC - Attention: Flex Claims Department

1350 DIVISION ROAD, SUITE 301 WEST WARWICK, RI 02893 TOLL FREE PHONE: (800) 720-4460 TOLL FREE FAX: (866) 878-2800

(You may copy this form if additional forms are needed)

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Claim Filing Requirements

1. ***Print your name, address, social security number or employee ID (EID) as appropriate and your employer's name.***

2. ***List expenses by date & arrange the supporting statements in the same order.*** Highlight or circle the service dates on your documentation. If you have several statements from the same provider, you may subtotal them and list them on one line with a range of dates.
   - Day care claims - complete the Dependent Care Assistance section
   - Health care claims - complete the Unreimbursed Medical Benefits section (The amount column should be the amount you are requesting after any insurance payment or provider discount for each expense).

3. ***Enclose required documentation****. A written statement from the dependent care or medical (Dr., hospital, pharmacy, etc.) provider of the service or an insurance company benefits statement showing all of the following:
   - The name of the dependent care or medical service provider,
   - The date or range of dates of medical service or day care. Although this date may be the same as the date paid it must be clear on what date the service was provided. The services must have already been provided.
   - A description of the service provided (for example, for health care, "dental cleaning", or for day care "day care"),
   - The name of the person or persons receiving the medical or dependent care, and
   - The cost of the service, not just the amount paid.

   ***Dependent Care claims only.** - You may either provide documentation from the day care provider or have the provider complete the Dependent Care Assistance Section, then sign on the "Provider's Signature" line and date the signature. You do not need to do both.

   Requests filed without the above documentation cannot be processed and will be returned.

4. ***Sign*** the claim form.

5. ***Keep*** copies for your tax records.

6. ***Mail*** to the address on the front of this form or ***Fax to (800) 201-7898***.

Over-the-counter medicines & drugs: Additional filing requirements for plans allowing these under the medical FSA:
- The receipt or documentation from the store must include the name of the drug printed on the receipt. This information must be provided by the store, not just listed by the participant on the receipt or on the claim form.
- The participant must indicate the existing or imminent medical condition on the receipt, on the claim form, or on a separate enclosed statement each time these items are claimed. Purchases for general good health will not be accepted.
- To claim vitamins, herbs or nutritional supplements, you must have a written diagnosis of the medical condition and "prescription" of all specific items for that condition on file with the Health & Welfare Department. You must renew this physician notice every 12 months and file it with the claims office with the first claim submitted for those items each plan year.

Orthodontics: In order to receive reimbursement for orthodontic treatment a copy of the payment arrangement you have made with the service provider must accompany your claim. If you have agreed to a one time payment for the full cost of the treatment please send a statement which shows the start date of the treatment and the total amount due after any insurance. If you will be submitting for reimbursement based on a payment arrangement please submit a copy of the agreement showing the start date of the treatment, the total cost of the treatment as well as the dollar amount and number of payments to be made. You will be eligible to receive reimbursement for payments as the due dates occur.

Medical equipment: Requires a letter from a physician every 12 months stating the nature of your medical condition, the specific equipment needed and that the equipment is essential to the treatment.

Claims payment and account information available 24 hours a day 7 days a week: - Complete history including available funds *on the Web* at www.teamcornerstone.com/flexhelp (Account Detail). You will need your login information, which you can find on your enrollment confirmation.

Claim forms: You may copy this form, obtain forms on the Internet at http://www.teamcornerstone.com/flexhelp, or request them from your personnel/payroll office, or call Cornerstone at 1-800-720-4460.